



Facility Name & ID Number Lexington Health Care Center-Lombard# 0028860 Report Period Beginning: 01/01/04 Ending: 12/31/04

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>224</u>	Skilled (SNF)	<u>224</u>	<u>81,984</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>224</u>	TOTALS	<u>224</u>	<u>81,984</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>25,450</u>	<u>15,212</u>	<u>8,734</u>	<u>49,396</u>	8
9	SNF/PED					9
10	ICF	<u>10,524</u>	<u>13,392</u>	<u>1,009</u>	<u>24,925</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>35,974</u>	<u>28,604</u>	<u>9,743</u>	<u>74,321</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 90.65%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been  
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 10/09/1984

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date New constructionNO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number  
of beds certified 224 and days of care provided 8,238Medicare Intermediary AdminaStar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH\* ☐CASH\* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/04 Ending: 12/31/04

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	340,850	36,514	11,697	389,061		389,061		389,061			1
2	Food Purchase		312,782		312,782		312,782	(12,471)	300,311			2
3	Housekeeping	265,678	31,591		297,269		297,269	324	297,593			3
4	Laundry	85,279	22,289		107,568		107,568	(9,126)	98,442			4
5	Heat and Other Utilities			250,500	250,500		250,500	3,703	254,203			5
6	Maintenance	30,811		107,263	138,074		138,074	47,573	185,647			6
7	Other (specify):* Allocated Benefits							5,354	5,354			7
8	<b>TOTAL General Services</b>	722,618	403,176	369,460	1,495,254		1,495,254	35,357	1,530,611			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,291,541	196,708	45,853	3,534,102		3,534,102	62,539	3,596,641			10
10a	Therapy			757,550	757,550		757,550		757,550			10a
11	Activities	237,947	19,506	3,420	260,873		260,873		260,873			11
12	Social Services	86,030		2,617	88,647		88,647		88,647			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Allocated Benefits							7,562	7,562			15
16	<b>TOTAL Health Care and Programs</b>	3,615,518	216,214	833,440	4,665,172		4,665,172	70,101	4,735,273			16
	<b>C. General Administration</b>											
17	Administrative	104,437		1,108,458	1,212,895		1,212,895	(1,003,200)	209,695			17
18	Directors Fees											18
19	Professional Services			101,150	101,150		101,150	(20,220)	80,930			19
20	Dues, Fees, Subscriptions & Promotions			5,136	5,136		5,136	971	6,107			20
21	Clerical & General Office Expenses	169,134	39,120	18,761	227,015		227,015	295,715	522,730			21
22	Employee Benefits & Payroll Taxes			626,428	626,428		626,428	12,353	638,781			22
23	Inservice Training & Education			2,376	2,376		2,376		2,376			23
24	Travel and Seminar			2,609	2,609		2,609	4,039	6,648			24
25	Other Admin. Staff Transportation			198	198		198	10,391	10,589			25
26	Insurance-Prop.Liab.Malpractice			212,733	212,733		212,733	4,626	217,359			26
27	Other (specify):* Allocated Benefits							45,620	45,620			27
28	<b>TOTAL General Administration</b>	273,571	39,120	2,077,849	2,390,540		2,390,540	(649,705)	1,740,835			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,611,707	658,510	3,280,749	8,550,966		8,550,966	(544,247)	8,006,719			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			115,241	115,241		115,241	145,011	260,252			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,745	2,745		2,745	153,497	156,242			32
33	Real Estate Taxes							150,481	150,481			33
34	Rent-Facility & Grounds			1,345,673	1,345,673		1,345,673	(1,344,181)	1,492			34
35	Rent-Equipment & Vehicles			8,984	8,984		8,984	3,146	12,130			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,472,643	1,472,643		1,472,643	(892,046)	580,597			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		241,412		241,412		241,412		241,412			39
40	Barber and Beauty Shops			38,658	38,658		38,658		38,658			40
41	Coffee and Gift Shops			2,654	2,654		2,654		2,654			41
42	Provider Participation Fee			122,976	122,976		122,976		122,976			42
43	Other (specify):* <b>Nonallowable Costs</b>			133,234	133,234		133,234	(133,234)				43
44	<b>TOTAL Special Cost Centers</b>		241,412	297,522	538,934		538,934	(133,234)	405,700			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,611,707	899,922	5,050,914	10,562,543		10,562,543	(1,569,527)	8,993,016			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**      A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
<b>NON-ALLOWABLE EXPENSES</b>				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(118)	2		4
5 Telephone, TV & Radio in Resident Rooms	(409)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients	(9,126)	4		8
9 Non-Straightline Depreciation	1,319	30		9
10 Interest and Other Investment Income	(15,220)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(1,930)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(3,640)	43		18
19 Entertainment				19
20 Contributions	(2,500)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(59,080)	43		24
25 Fund Raising, Advertising and Promotional	(12,409)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax	(53,439)	43		26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See attached Schedule A	(54,537)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (211,089)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(1,358,438)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (1,358,438)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (1,569,527)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
 (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington Health Care Center-Lombard**  
**Provider # 0028660**  
**01/01/04 to 12/31/04**

**Schedule A**

VI. Adjustment Detail  
Line 29 - Other

Description	Amount	Reference
Offset miscellaneous income	(209)	21
Disallow unclaimed property costs	(1,552)	21
Disallow radiology	(8,611)	43
Disallow laboratory	(3,838)	43
Disallow personal item replacement	(817)	43
Non-allowable collection fees	(37,546)	19
Disallow out of period legal fees	(1,964)	19
Total	<u>(54,537)</u>	

**SEE ACCOUNTANTS' COMPILATION REPORT**

Lexington Health Care Center-Lombard

ID# 0028860

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

12/31/04

12/31/04

[illegible]



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number    Lexington Health Care Center-Lombard    #    0028860    Report Period Beginning:    01/01/04    Ending:    12/31/04

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	1,319	112,287	0	31,405	0	0	0	0	0	0	0	145,011	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,220)	168,337	0	380	0	0	0	0	0	0	0	153,497	32
33	Real Estate Taxes	0	145,673	0	1,650	0	0	0	0	0	0	0	147,323	33
34	Rent-Facility & Grounds	0	(1,345,673)	0	1,492	0	0	0	0	0	0	0	(1,344,181)	34
35	Rent-Equipment & Vehicles	0	0	0	3,146	0	0	0	0	0	0	0	3,146	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(13,901)</b>	<b>(919,376)</b>	<b>0</b>	<b>38,073</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(895,204)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(133,407)	13,439	0	0	0	0	0	0	0	0	0	(119,968)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(133,407)</b>	<b>13,439</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(119,968)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(156,552)</b>	<b>(902,212)</b>	<b>553,522</b>	<b>(1,009,748)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,514,990)</b>	<b>45</b>

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	33.33%			Lexington Health		
John Samatas	33.33%	See Attached Schedule B	See Attached	Care Systems of		
Cynthia Thiem	33.34%		Schedule B	Lombard Ltd. Ptsp.	Lombard	Real Estate Ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rental expense	\$ 1,345,673	Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	\$	\$ (1,345,673) 1
2	V	19 Professional fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	3,276	3,276 2
3	V	21 Bank charges		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	449	449 3
4	V	30 Depreciation		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	112,287	112,287 4
5	V	32 Interest expense		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	165,883	165,883 5
6	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	2,454	2,454 6
7	V	33 Property taxes		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	145,673	145,673 7
8	V	43 State replacement tax		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	13,439	13,439 8
9	V						9
10	V						10
11	V			** - The owners of Lexington Health Care Center of Lombard, Inc. own			11
12	V			100% of Lexington Health Care Systems of Lombard Limited Partnership			12
13	V						13
14	Total		\$ 1,345,673			\$ 443,461	\$ * (902,212) 14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington Health Care Center of Lombard, Inc.**

**Provider # 0028660**

**1/1/04 - 12/31/04**

**Schedule B**

VII. Related Parties

Related Nursing Homes

<u>Name of facility</u>	<u>City</u>
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Bloomingdale, Inc.	Bloomington
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

**See Accountants' Compilation Report**

Facility Name &amp; ID Number Lexington Health Care Center-Lombard

# 0028860

Report Period Beginning: 01/01/04

Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 324	\$ 324
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	3,521	3,521
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	93	93
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	89	89
19	V	6 Management allocation - salaries		Royal Management Corp.	**	44,272	44,272
20	V	6 Repairs & maintenance		Royal Management Corp.	**	3,301	3,301
21	V	7 Management allocation - employee benefits		Royal Management Corp.	**	5,354	5,354
22	V	10 Management allocation - salaries		Royal Management Corp.	**	62,539	62,539
23	V	15 Management allocation - employee benefits		Royal Management Corp.	**	7,562	7,562
24	V	17 Management allocation - salaries		Royal Management Corp.	**	105,258	105,258
25	V	19 Computer consultant & supplies		Royal Management Corp.	**	11,783	11,783
26	V	19 Professional fees		Royal Management Corp.	**	7,389	7,389
27	V	20 Dues & subscriptions		Royal Management Corp.	**	871	871
28	V	20 Licenses, permits & inspections		Royal Management Corp.	**	23	23
29	V	20 Advertising - help wanted		Royal Management Corp.	**	77	77
30	V	21 Management allocation - salaries		Royal Management Corp.	**	272,001	272,001
31	V	21 Bank charges		Royal Management Corp.	**	2,164	2,164
32	V	21 Office supplies & printing		Royal Management Corp.	**	9,192	9,192
33	V	21 Postage		Royal Management Corp.	**	3,766	3,766
34	V	21 Telephone		Royal Management Corp.	**	9,904	9,904
35	V	24 Travel & seminar		Royal Management Corp.	**	4,039	4,039
36	V						
37	V						
38	V	** Certain owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.					
39	Total		\$			\$ 553,522	\$ * 553,522

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington Health Care Center-Lombard

# 0028860

Report Period Beginning: 01/01/04

Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	25 Auto expense	\$	Royal Management Corp.	**	\$ 10,391	\$ 10,391	15
16	V	26 Insurance general		Royal Management Corp.	**	4,626	4,626	16
17	V	27 Management allocation - employee benefits		Royal Management Corp.	**	45,620	45,620	17
18	V	30 Depreciation - vehicles		Royal Management Corp.	**	3,370	3,370	18
19	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	7,307	7,307	19
20	V	30 Depreciation - equipment		Royal Management Corp.	**	20,728	20,728	20
21	V	32 Interest		Royal Management Corp.	**	380	380	21
22	V	33 Property taxes		Royal Management Corp.	**	1,650	1,650	22
23	V	34 Rent expense		Royal Management Corp.	**	1,492	1,492	23
24	V	35 Equipment rental		Royal Management Corp.	**	3,146	3,146	24
25	V	17 Management fees	1,108,458	Royal Management Corp.	**		(1,108,458)	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V	** Certain owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.						38
39	Total		\$ 1,108,458			\$ 98,710	\$ * (1,009,748)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number      Lexington Health Care Center-Lombard      #      0028860      Report Period Beginning:      01/01/04      Ending:      12/31/04

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule C	2	4%	Salary	\$ 35,026	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops.	33.33%	See Schedule C	3	6%	Salary	25,019	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule C	3	6%	Salary	25,019	L17, C7	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	7%	Salary	6,094	L17, C7	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	4	8%	Salary	14,100	L17, C7	5
6											6
7											7
8						All individuals work in excess of 40 hours per week.					8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 105,258		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington Health Care Center of Lombard, Inc.**  
**Provider # 0028660**  
**1/1/04 - 12/31/04**

**Schedule C**

VII. Related Parties

C. Statement of Compensation and Other Payments to Owners, Relatives  
and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

<u>Name of facility</u>	<u>John Samatas</u>	<u>James Samatas</u>	<u>Cynthia Thiem</u>	<u>George Samatas</u>	<u>Jason Samatas</u>	<u>Total</u>
Lexington Health Care Center of Bloomingdale, Inc.	19,211	26,895	19,211	4,679	10,827	80,823
Lexington Health Care Center of Chicago Ridge, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Elmhurst, Inc.	16,754	23,455	16,754	4,081	9,442	70,486
Lexington Health Care Center of LaGrange, Inc.	12,174	17,044	12,174	2,965	6,861	51,218
Lexington Health Care Center of Lake Zurich, Inc.	23,790	33,306	23,790	5,795	13,408	100,089
Lexington Health Care Center of Orland Park, Inc.	30,154	42,219	30,154	7,346	16,995	126,868
Lexington Health Care Center of Schaumburg, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Streamwood, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Wheeling, Inc.	24,684	34,557	24,684	6,012	13,912	103,849
Total	201,824	282,554	201,824	49,160	113,745	849,107

**See Accountants' Compilation Report**

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Royal Management Corp.  
 Street Address 665 W. North Avenue, Suite 500  
 City / State / Zip Code Lombard, IL 60148  
 Phone Number ( 630) 458-4700  
 Fax Number ( 630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	743,346	10	\$ 2,938	\$	81,984	324	1
2	5	Utilities - gas & electric	Bed Days	743,346	10	31,920		81,984	3,521	2
3	5	Utilities - water & sewer	Bed Days	743,346	10	846		81,984	93	3
4	5	Utilities - maintenance office	Bed Days	743,346	10	808		81,984	89	4
5	6	Management allocation - salaries	Bed Days	743,346	10	401,410	401,410	81,984	44,272	5
6	6	Repairs & maintenance	Bed Days	743,346	10	29,930		81,984	3,301	6
7	7	Management allocation - employee	Bed Days	743,346	10	48,540		81,984	5,354	7
8	10	Management allocation - salaries	Bed Days	743,346	10	567,037	567,037	81,984	62,539	8
9	15	Management allocation - employee	Bed Days	743,346	10	68,569		81,984	7,562	9
10	17	Management allocation - salaries	Bed Days	743,346	10	954,365	954,365	81,984	105,258	10
11	19	Computer consultant & supplies	Bed Days	743,346	10	106,838		81,984	11,783	11
12	19	Professional fees	Bed Days	743,346	10	66,993		81,984	7,389	12
13	20	Dues & subscriptions	Bed Days	743,346	10	7,893		81,984	871	13
14	20	Licenses, permits & inspections	Bed Days	743,346	10	212		81,984	23	14
15	20	Advertising - help wanted	Bed Days	743,346	10	698		81,984	77	15
16	21	Management allocation - salaries	Bed Days	743,346	10	2,466,223	2,466,223	81,984	272,001	16
17	21	Bank charges	Bed Days	743,346	10	19,618		81,984	2,164	17
18	21	Office supplies & printing	Bed Days	743,346	10	83,348		81,984	9,192	18
19	21	Postage	Bed Days	743,346	10	34,142		81,984	3,766	19
20	21	Telephone	Bed Days	743,346	10	89,797		81,984	9,904	20
21	24	Travel & seminar	Bed Days	743,346	10	36,624		81,984	4,039	21
22										22
23										23
24										24
25	TOTALS					\$ 5,018,749	\$ 4,389,035		\$ 553,522	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Royal Management Corp.  
 Street Address 665 W. North Avenue, Suite 500  
 City / State / Zip Code Lombard, IL 60148  
 Phone Number ( 630) 458-4700  
 Fax Number ( 630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	743,346	10	\$ 94,217	\$ 81,984	\$ 10,391	1
2	26	Insurance general	Bed Days	743,346	10	41,943	81,984	4,626	2
3	27	Management allocation - employee	Bed Days	743,346	10	413,634	81,984	45,620	3
4	30	Depreciation - vehicles	Bed Days	743,346	10	30,557	81,984	3,370	4
5	30	Depreciation - leasehold improv.	Bed Days	743,346	10	66,255	81,984	7,307	5
6	30	Depreciation - equipment	Bed Days	743,346	10	187,937	81,984	20,728	6
7	32	Interest	Bed Days	743,346	10	3,446	81,984	380	7
8	33	Property taxes	Bed Days	743,346	10	14,963	81,984	1,650	8
9	34	Rent expense	Bed Days	743,346	10	13,526	81,984	1,492	9
10	35	Equipment rental	Bed Days	743,346	10	28,527	81,984	3,146	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 895,005	\$	\$ 98,710	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard# 0028860

Report Period Beginning:

01/01/04

Ending:

12/31/04

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	GMAC		X	Mortgage	\$39,766.00	4/11/94	\$ 3,978,766	\$ 1,742,898	4/11/09	0.0875	\$ 165,883	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	LaSalle Bank, N.A.		X	Line of Credit	Varies	04/06/02	750,000	260,000	5/31/05	Prime	2,745	6	
7												7	
8												8	
9	TOTAL Facility Related				\$39,766.00		\$ 4,728,766	\$ 2,002,898			\$ 168,628	9	
	B. Non-Facility Related*												
10								Interest income offset			(15,220)	10	
11								Amortization of mortgage costs			2,454	11	
12								Allocation from management company			380	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (12,386)	14	
15	TOTALS (line 9+line14)						\$ 4,728,766	\$ 2,002,898			\$ 156,242	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Lexington Health Care Center-Lombard**# **0028860**Report Period Beginning: **01/01/04**Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2003 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>139,500</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		Allocated from management company	\$	<b>1,650</b>	
		2003	\$	<b>141,173</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>3,323</b>	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>144,000</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	<b>3,158</b>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
<b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>150,481</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1999	<b>135,483</b>	8		
	2000	<b>133,908</b>	9		
	2001	<b>137,587</b>	10		
	2002	<b>141,180</b>	11		
	2003	<b>141,173</b>	12		
2004 tax assessment:	<b>2,279,570</b>				
Equalization factor:	<b>1</b>				
Tax rate:	<b>0.06303</b>				
Est. 2004 tax payable '05	<b>143,681</b>				
Use:	<b>144,000</b>				

<b>FOR OHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
14	PLUS APPEAL COST FROM LINE 5 \$ 14
15	LESS REFUND FROM LINE 6 \$ 15
16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Lexington Health Care Center-Lombard COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0028860

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-19-307-002</u>		\$ <u>141,173.00</u>	\$ <u>141,173.00</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-019</u>		\$ <u>187,600.00</u>	\$ <u>1,650.00</u>
4. _____		\$ _____	\$ _____
5. _____		\$ _____	\$ _____
6. _____		\$ _____	\$ _____
7. _____		\$ _____	\$ _____
8. _____		\$ _____	\$ _____
9. _____		\$ _____	\$ _____
10. _____		\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>328,773.00</u>	\$ <u>142,823.00</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services?        YES   X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,770
 B. General Construction Type:
 Exterior Concrete Block
 Frame Steel
 Number of Stories 3

C. Does the Operating Entity?
 (a) Own the Facility
 (X) (b) Rent from a Related Organization.
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (X) (a) Own the Equipment
 (X) (b) Rent equipment from a Related Organization.
 (X) (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Lombard Lexington Square Life Care, Inc.: Retirement Community; 261 units; 309,000 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 (X) NO
 If so, please complete the following:

1. Total Amount Incurred: N/A
 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A
 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	30,000	1984	\$ 616,761	1
2	Allocated from management company			17,683	2
3	TOTALS	30,000		\$ 634,444	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington Health Care Center-Lombard

# 0028860

Report Period Beginning:

01/01/04

Ending:

12/31/04

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	215	1984	1984	\$ 3,661,473	\$	35	\$ 104,614	\$ 104,614	\$ 2,116,241
5	9	1995	1995	284,156	8,119	35	8,119		77,128
6									
7									
8									
Improvement Type**									
9	Building Improvements	1990		96,217		10			96,217
10	Building Improvements	1991		71,493		10			71,493
11	Building Improvements	1994		20,200		10	1,010	1,010	20,200
12	Building Improvements	1995		14,535	415	35	415		3,946
13	Building Improvements - dishwasher hook	1996		2,748	275	10	275		2,336
14	Building Improvements - outside painting	1996		11,308	1,131	10	1,131		9,612
15	Building Improvements - dining room	1996		3,752	375	10	375		3,190
16	Leasehold Improvements	1992		16,299	466	35	466		5,822
17	Leasehold Improvements	1994		21,836	1,092	10	1,092		21,836
18	Leasehold Improvements - 2nd floor	1996		19,319	1,932	10	1,932		16,421
19	Leasehold Improvements - bathroom rehat	1996		9,216	922	10	922		7,834
20	Leasehold Improvements - fan coil repairs	1996		6,669	191	35	191		1,588
21	Land Improvements	1993		2,985	199	15	199		2,289
22	Land Improvements	1995		4,596	306	15	306		2,911
23	Capitalized Repairs	1986		1,730		10			1,730
24	Building Improvements - basement	1996		18,993	1,899	10	1,899		14,720
25	Leasehold Improvements - Corner Guards	1997		520	52	10	52		390
26	Leasehold Improvements - Corridor flooring	1997		10,381	1,038	10	1,038		7,785
27	BI: Kitchen Rehab	1998		2,494	249	10	249		1,621
28	Wiring for MDS project	1998		3,365	337	10	337		2,187
29	Install Fire Sprinklers in Mechanical Rms	1998		4,600	131	35	131		854
30	Tile for Lobby	1998		20,530	2,053	10	2,053		13,345
31	Walk in Freezers/Coolers	1998		3,182	91	35	91		591
32	Fire Wall Repairs	1998		12,410	355	35	355		2,305
33	Underground storage tank	1998		2,613		10	262	262	1,834
34	Repave parking lot	1999		7,625	508	15	508		2,796
35	Lounge Floor Tile	1999		2,964	296	10	296		1,630
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Rewire Building	1999	\$ 9,083	\$ 260	35	\$ 260		\$ 1,427		37
38	Heat exchanger for water heater	1999	1,660		5	166	166	1,660		38
39	Compressor and tank for freezer	1999	2,924		5	295	295	2,924		39
40	Plumbing Improvement	2000	2,833	283	10	283		1,275		40
41	Relocate 2nd floor sprinklers	2000	2,200	63	35	63		283		41
42	Water heater repairs	2000	3,831	766	5	766		3,448		42
43	Automatic door	2000	4,556	130	35	130		586		43
44	Install sprinklers	2001	6,082	608	10	608		2,179		44
45	Infrared curtains for elevator	2001	4,500	450	10	450		1,425		45
46	Elevator upgrade	2002	3,006	601	5	601		1,503		46
47	Condensor	2002	2,678	536	5	536		1,340		47
48	Resurfacing Parking Lot	2003	30,690	1,535	20	1,535		2,174		48
49	Plumbing loop repairs	2003	6,125	613	10	613		664		49
50	Fire alarm panel/call system	2003	8,495	425	20	425		814		50
51	Facility Rehab - Painting	2003	6,872	687	10	687		848		51
52	Facility Rehab - Floor Tile	2003	28,888	1,444	20	1,444		1,859		52
53	Nurse call system	2003	49,451	2,473	20	2,473		2,680		53
54	Brick paved sidewalk/entryway	2003	5,855	293	20	293		415		54
55	Facility redecorating - painting/wallpaper	2003	314,478	15,724	20	15,724		31,449		55
56	Fire alarm panel/call system	2003	276,327	13,816	20	13,816		27,634		56
57	Floor Tile	2003	58,720	2,936	20	2,936		5,873		57
58	Carpeting/cove base	2003	29,519	2,952	10	2,952		5,905		58
59	Water heater	2004	9,209	153	10	153		153		59
60	Kitchen sewer and dishroom	2004	31,232	130	20	130		130		60
61										61
62										62
63	Land improvements - management company	2002	27,870		15	1,843	1,843	5,419		63
64	Building - management company	2002	216,828		40	5,299	5,299	15,810		64
65	HVAC, electrical, security system - management company	2003	2,149		30	148	148	204		65
66	Key card system - management company	2004	338		20	17	17	17		66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 5,484,608	\$ 69,310		\$ 182,964	\$ 113,654	\$ 2,630,950		70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

Facility Name &amp; ID Number Lexington Health Care Center-Lombard

# 0028860

Report Period Beginning:

01/01/04

Ending:

12/31/04

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 456,898	\$ 44,621	\$ 51,880	\$ 7,259	3 - 10 yrs	\$ 228,032	71
72	Current Year Purchases	64,301	1,310	1,310		5 - 10 yrs	1,310	72
73	Fully Depreciated Assets	933,134					933,134	73
74	Allocated from management company	207,982		20,728	20,728		86,865	74
75	TOTALS	\$ 1,662,315	\$ 45,931	\$ 73,918	\$ 27,987		\$ 1,249,341	75

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from management company			43,526		3,370	3,370		29,907	79
80	TOTALS			\$ 43,526	\$	\$ 3,370	\$ 3,370		\$ 29,907	80

## E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,824,893	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 115,241	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 260,252	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 145,011	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,910,198	85

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

## G. Construction-in-Progress

	Description	Cost	
92	Therapy & Reception Rehab	\$ 46,630	92
93			93
94			94
95		\$ 46,630	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT



**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from management company				1,492			6
7	TOTAL				\$ 1,492			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 12,130 Description: Postage meter - \$179; Copier - \$8,535; Fax Machine - \$270; Allocated from management company - \$3,146  
(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2005 \$ \_\_\_\_\_

13. \_\_\_\_\_/2006 \$ \_\_\_\_\_

14. \_\_\_\_\_/2007 \$ \_\_\_\_\_

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building,  
please provide complete details on attached  
schedule.

\*\* This amount plus any amortization of lease  
expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b> It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input type="checkbox"/> YES  <input checked="" type="checkbox"/> NO	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
 SEE ACCOUNTANTS' COMPILATION REPORT

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	4,147	\$ 287,574	\$	4,147	\$ 287,574	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,218	79,027		1,218	79,027	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		8,231	390,949		8,231	390,949	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				241,412		241,412	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	13,596	\$ 757,550	\$ 241,412	13,596	\$ 998,962	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 814,704	\$ 815,860	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 500,000 )	1,820,570	1,820,570	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,562	55,562	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	620	620	8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,691,456	\$ 2,692,612	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		634,444	13
14	Buildings, at Historical Cost		3,661,473	14
15	Leasehold Improvements, at Historical Cost	1,379,113	1,823,135	15
16	Equipment, at Historical Cost	494,606	1,705,841	16
17	Accumulated Depreciation (book methods)	(515,118)	(3,910,198)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: Construction in progr	46,630	46,630	22
23	Other(specify): Unamortized loan costs		10,637	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,405,231	\$ 3,971,962	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,096,687	\$ 6,664,574	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 384,030	\$ 384,030	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	260,000	260,000	29
30	Accrued Salaries Payable	269,057	269,057	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,356	3,356	31
32	Accrued Real Estate Taxes(Sch.IX-B)		144,000	32
33	Accrued Interest Payable		8,600	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See attached Schedule E	143,688	168,591	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,060,131	\$ 1,237,634	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,742,898	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 1,742,898	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,060,131	\$ 2,980,532	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 3,036,556	\$ 3,684,042	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,096,687	\$ 6,664,574	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**Lexington Health Care Center of Lombard, Inc.**  
**Provider # 0028860**  
**1/1/04 - 12/31/04**

**Schedule E**

XV. Balance Sheet  
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Bond Withholding	1,876	1,876
Accrued Rent	40,097	
Accrued 401 (k) contribution	21,906	21,906
Other accrued expenses	41,905	41,905
Due to related party	37,904	37,904
Due to partners		65,000
Total line 36	143,688	168,591

XVII. Income Statement  
E. Other Revenue

28. Other Revenue

Description	Amount
Service Availability Fee	561,552
Miscellaneous Income	209
Vending Machine Commissions	1374
Total line 28	563,135

**See Accountants' Compilation Report**

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 3,661,041</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>Post closing adjustments</b>	<b>(392,558)</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 3,268,483</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>2,198,073</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(2,430,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (231,927)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 3,036,556</b>	<b>24</b>

Operating Entity Only

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number Lexington Health Care Center-Lombard

# 0028860

Report Period Beginning: 01/01/04

Ending:

12/31/04

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,079,894	1
2	Discounts and Allowances for all Levels	(769,746)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,310,148	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,340,879	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,340,879	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,862	12
13	Barber and Beauty Care	47,591	13
14	Non-Patient Meals	118	14
15	Telephone, Television and Radio	65	15
16	Rental of Facility Space		16
17	Sale of Drugs	344,326	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,148	19
20	Radiology and X-Ray	10,621	20
21	Other Medical Services	100,377	21
22	Laundry	9,126	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 531,234	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	15,220	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 15,220	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See attached Schedule E</b>	563,135	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 563,135	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 12,760,616	30

2			
	Expenses	Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,495,254	31
32	Health Care	4,665,172	32
33	General Administration	2,390,540	33
<b>B. Capital Expense</b>			
34	Ownership	1,472,643	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	415,958	35
36	Provider Participation Fee	122,976	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,562,543	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	2,198,073	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 2,198,073	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
This entity files a cash basis tax return.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Lexington Health Care Center-Lombard**# **0028860**Report Period Beginning: **01/01/04**Ending: **12/31/04**

12/31/04

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,503	1,798	\$ 101,202	\$ 56.29	1
2	Assistant Director of Nursing	3,836	4,009	126,890	31.65	2
3	Registered Nurses	37,896	41,478	1,165,450	28.10	3
4	Licensed Practical Nurses	20,233	22,129	523,332	23.65	4
5	Nurse Aides & Orderlies	19,192	20,786	207,198	9.97	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	95,695	102,119	1,167,469	11.43	8
9	Activity Director	1,967	2,177	30,932	14.21	9
10	Activity Assistants	18,951	20,771	207,015	9.97	10
11	Social Service Workers	4,027	4,176	86,030	20.60	11
12	Dietician	2,041	2,085	28,406	13.62	12
13	Food Service Supervisor	1,928	2,241	35,456	15.82	13
14	Head Cook	2,049	2,170	39,899	18.39	14
15	Cook Helpers/Assistants	13,026	13,941	117,913	8.46	15
16	Dishwashers	17,382	18,609	119,176	6.40	16
17	Maintenance Workers	1,914	2,136	30,811	14.42	17
18	Housekeepers	36,388	38,943	265,678	6.82	18
19	Laundry	12,207	13,132	85,279	6.49	19
20	Administrator	1,667	2,103	104,437	49.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,718	11,763	169,134	14.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	302,620	326,566	\$ 4,611,707 *	\$ 14.12	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	230	\$ 11,697	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant	13	712	L10, C3	37
38	Nurse Consultant	14	763	L10, C3	38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	72	3,420	L11, C3	44
45	Social Service Consultant	58	2,617	L12, C3	45
46	Other(specify)				46
47	Rehabcare Consultant	Monthly	1,593	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	387	\$ 46,002		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number    **Lexington Health Care Center-Lombard**

**XIX. SUPPORT SCHEDULES**

STATE OF ILLINOIS

#    **0028860**

Report Period Beginning:    **01/01/04**

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Ending:    **12/31/04**

<p><b>A. Administrative Salaries</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 15%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 45%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Nancy McDonald</td> <td>Administrator</td> <td>0.00%</td> <td style="text-align: right;">\$ 104,437</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td style="text-align: right;">\$ 104,437</td> </tr> </tbody> </table> <p><b>B. Administrative - Other</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Description</th> <th style="width: 30%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Management fees (eliminated in Column 7)</td> <td style="text-align: right;">\$ 1,108,458</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)</td> <td style="text-align: right;">\$ 1,108,458</td> </tr> </tbody> </table> <p><b>C. Professional Services</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Vendor/Payee</th> <th style="width: 20%;">Type</th> <th style="width: 50%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Altschuler, Melvoin &amp; Glasser LLP</td> <td>Accounting</td> <td style="text-align: right;">\$ 15,565</td> </tr> <tr> <td>American Express Tax &amp; Bus. Svs.</td> <td>Accounting</td> <td style="text-align: right;">6,795</td> </tr> <tr> <td>Avail Corporation</td> <td>Accounting</td> <td style="text-align: right;">820</td> </tr> <tr> <td>Cassiday, Shade &amp; Gloor</td> <td>Legal</td> <td style="text-align: right;">7,614</td> </tr> <tr> <td>Freedman, Anselmo &amp; Lindberg</td> <td>Collections</td> <td style="text-align: right;">2,277</td> </tr> <tr> <td>Grabowski Law Center</td> <td>Collections</td> <td style="text-align: right;">35,269</td> </tr> <tr> <td>Katten Muchin, Zavis &amp; Rosenman</td> <td>Legal</td> <td style="text-align: right;">1,264</td> </tr> <tr> <td>Personnel Planners</td> <td>U/C Consultant</td> <td style="text-align: right;">1,646</td> </tr> <tr> <td>James Samatas</td> <td>Legal</td> <td style="text-align: right;">125</td> </tr> <tr> <td>Sachnoff &amp; Weaver</td> <td>Legal</td> <td style="text-align: right;">13,784</td> </tr> <tr> <td>Carilyn Jeschke</td> <td>Staffing Consultant</td> <td style="text-align: right;">869</td> </tr> <tr> <td>See attached Schedule F</td> <td> </td> <td style="text-align: right;">15,122</td> </tr> <tr> <td colspan="2">TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)</td> <td style="text-align: right;">\$ 101,150</td> </tr> </tbody> </table>	Name	Function	Ownership %	Amount	Nancy McDonald	Administrator	0.00%	\$ 104,437																					TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 104,437	Description	Amount	Management fees (eliminated in Column 7)	\$ 1,108,458					TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 1,108,458	Vendor/Payee	Type	Amount	Altschuler, Melvoin & Glasser LLP	Accounting	\$ 15,565	American Express Tax & Bus. 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Schedule of Non-Cash Compensation Paid to Owners or Employees</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Description</th> <th style="width: 10%;">Line #</th> <th style="width: 50%;">Amount</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td style="text-align: right;">\$  </td> </tr> <tr> <td>N/A</td> <td> </td> <td style="text-align: right;"> </td> </tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr> <td>TOTAL</td> <td> </td> <td style="text-align: right;">\$  </td> </tr> </tbody> </table>	Description	Amount	Workers' Compensation Insurance	\$ 80,376	Unemployment Compensation Insurance	36,761	FICA Taxes	342,616	Employee Health Insurance	123,965	Employee Meals	12,353	Illinois Municipal Retirement Fund (IMRF)*		401(k) Contribution	17,745	Other Employee Benefits	20,037	Life Insurance	4,928							TOTAL (agree to Schedule V, line 22, col.8)	\$ 638,781	Description	Line #	Amount			\$	N/A																											TOTAL		\$	<p><b>F. 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\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Lexington Health Care Center of Lombard, Inc.  
**Provider # 0028860**  
**1/1/04 - 12/31/04**

**Schedule F**

XIX. Support Schedules  
C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Serpico, Novelle, Petrosino	Legal	2,753
Information Controls, Inc.	Computer Consultant	1,156
Gigatrend	Computer Consultant	195
Lanac	Computer Consultant	792
Advanced Answers on Demand, Inc.	Computer Consultant	2,652
E Health Data Solutions	Computer Consultant	3,600
National Datacare Corp.	Computer Consultant	1,306
XO Communications	Computer Consultant	2,272
AdminaStar	Computer Consultant	396
		<hr/>
		15,122
		<hr/>
Total, Agrees to Schedule V, Line 19, Column 3		101,150
		<hr/>
Allocated from management co:		
American Express Tax & Business Services	Accounting	335
Altschuler, Melvoin and Glasser LLP	Accounting	534
Account Temps	Accounting	912
Avail Corporation	Accounting	26
Doris Fischer	Medicaid Billing Consultant	2,348
Gene Whitehorn	Medicaid Billing Consultant	811
Susan Parker, LCSW	DNR Consulting	12
Personnel Planners	U/C Consulting	13
Gilson, Labus and Silverman	Accounting	276
James Samatas	Legal	39
Sachnoff and Weaver	Legal	1,094
ING / Pension Administrators	401 (k) Administration	959
Eric Haider	Consulting	29
Various	Computer Consulting	11,783
Allocated from building partnership:		
James Samatas	Filing and recording fees	118
Tax Caps.Com	Tax assessment appeal	3,158
Reclassifications		
Tax Caps.Com	Tax assessment appeal	(3,158)
Nonallowable legal fees:		
Freedman, Anselmo, & Lindberg	Legal-collection fees	(250)
Grabowski Law Center, LLC	Legal-collection fees	(35,269)
Various Collections	Collection fees	(2,027)
Sachnoff & Weaver, Ltd.	Out of Period legal fees	(934)
Katten, Muchin, Zavis & Rosenman	Out of Period legal fees	(1,029)
		<hr/>
Total, Agrees to Schedule V, Line 19, Column 8		80,930
		<hr/>

**See accountants' compilation report**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2						N/A							
3													
4													
5													
6													
7													
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10													
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15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard

STATE OF ILLINOIS

# 0028860

Report Period Beginning:

01/01/04

Ending:

Page 23

12/31/04

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7.5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 57,763 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES N/A NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 122,976  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 12,353 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 118
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	340,850	36,514	11,697	389,061	0	389,061	0	389,061
2. Food Purchase	0	312,782	0	312,782	0	312,782	-12,471	300,311
3. Housekeeping	265,678	31,591	0	297,269	0	297,269	324	297,593
4. Laundry	85,279	22,289	0	107,568	0	107,568	-9,126	98,442
5. Heat and Other Utilities	0	0	250,500	250,500	0	250,500	3,703	254,203
6. Maintenance	30,811	0	107,263	138,074	0	138,074	47,573	185,647
7. Other (specify)*	0	0	0	0	0	0	5,354	5,354
8. Total General Services	722,618	403,176	369,460	1,495,254	0	1,495,254	35,357	1,530,611
9. Medical Director	0	0	24,000	24,000	0	24,000	0	24,000
10. Nursing & Medical Records	3,291,541	196,708	45,853	3,534,102	0	3,534,102	62,539	3,596,641
10a. Therapy	0	0	757,550	757,550	0	757,550	0	757,550
11. Activities	237,947	19,506	3,420	260,873	0	260,873	0	260,873
12. Social Services	86,030	0	2,617	88,647	0	88,647	0	88,647
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	7,562	7,562
16. Total Health Care & Programs	3,615,518	216,214	833,440	4,665,172	0	4,665,172	70,101	4,735,273
17. Administrative	104,437	0	1,108,458	1,212,895	0	1,212,895	-1,003,200	209,695
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	101,150	101,150	0	101,150	-20,220	80,930
20. Fees, Subscriptions & Promotion	0	0	5,136	5,136	0	5,136	971	6,107
21. Clerical & General Office	169,134	39,120	18,761	227,015	0	227,015	295,715	522,730
22. Employee Benefits & Payroll	0	0	626,428	626,428	0	626,428	12,353	638,781
23. Inservice Training & Education	0	0	2,376	2,376	0	2,376	0	2,376
24. Travel and Seminar	0	0	2,609	2,609	0	2,609	4,039	6,648
25. Other Admin. Staff Trans	0	0	198	198	0	198	10,391	10,589
26. Insurance-Prop.Liab.Malpractice	0	0	212,733	212,733	0	212,733	4,626	217,359
27. Other (specify)*	0	0	0	0	0	0	45,620	45,620
28. Total General Adminis	273,571	39,120	2,077,849	2,390,540	0	2,390,540	-649,705	1,740,835
29. Total General Administrative	4,611,707	658,510	3,280,749	8,550,966	0	8,550,966	-544,247	8,006,719
30. Depreciation	0	0	115,241	115,241	0	115,241	145,011	260,252
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	2,745	2,745	0	2,745	153,497	156,242
33. Real Estate	0	0	0	0	0	0	150,481	150,481
34. Rent - Facility & Grounds	0	0	1,345,673	1,345,673	0	1,345,673	-1,344,181	1,492
35. Rent - Equipment & Vehicles	0	0	8,984	8,984	0	8,984	3,146	12,130
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	1,472,643	1,472,643	0	1,472,643	-892,046	580,597
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	241,412	0	241,412	0	241,412	0	241,412
40. Barber and Beauty Shop	0	0	38,658	38,658	0	38,658	0	38,658
41. Coffee and Gift Shops	0	0	2,654	2,654	0	2,654	0	2,654
42. Provider Participation	0	0	122,976	122,976	0	122,976	0	122,976
43. Other (specify):*	0	0	133,234	133,234	0	133,234	-133,234	0
44. Total Special Cost Ce	0	241,412	297,522	538,934	0	538,934	-133,234	405,700
45. Grand Total	4,611,707	899,922	5,050,914	10,562,543	0	10,562,543	-1,569,527	8,993,016

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	814,704	815,860
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	1,820,570	1,820,570
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	55,562	55,562
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	620	620
9. Other (specify):	0	0
10. Total current assets	2,691,456	2,692,612
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	634,444
14. Buildings, at Historical Cost	0	3,661,473
15. Leasehold Improvements, Historical Cost	1,379,113	1,823,135
16. Equipment, at Historical Cost	494,606	1,705,841
17. Accumulated Depreciation (book methods)	-515,118	-3,910,198
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	46,630	46,630
23. other (specify):	0	10,637
24. Total Long-Term Assets	1,405,231	3,971,962
25. Total Assets	4,096,687	6,664,574
CURRENT LIABILITIES		
26. Accounts Payable	384,030	384,030
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	260,000	260,000
30. Accrued Salaries Payable	269,057	269,057
31. Accrued Taxes Payable	3,356	3,356
32. Accrued Real Estate Taxes	0	144,000
33. Accrued Interest Payable	0	8,600
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	143,688	168,591
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,060,131	1,237,634
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	1,742,898
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	1,742,898
46. Total Liabilities	1,060,131	2,980,532
47. Total Equity	3,036,556	3,684,042
48. Total Liabilities and Equity	4,096,687	6,664,574

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	11,079,894
2. Discounts and Allowances for all Levels	-769,746
Subtotal - Inpatient Care	10,310,148
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,340,879
7. Oxygen	0
Subtotal - Ancillary Revenue	1,340,879
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	2,862
13. Barber and Beauty Care	47,591
14. Non-Patient Meals	118
15. Telephone, Television, and Radio	65
16. Rental of Facility Space	0
17. Sale of Drugs	344,326
18. Sale of Supplies to Non-Patients	0
19. Laboratory	16,148
20. Radiology and X-Ray	10,621
21. Other Medical Services	100,377
22. Laundry	9,126
Subtotal - Other Operating Revenue	531,234
24. Contributions	0
25. Interest and Other Investments Income	15,220
Subtotal - Non-Operating Revenue	15,220
27. Other Revenue (specify):	0
28. Other Revenue (specify):	563,135
Subtotal - Other Revenue	563,135
30. Total Revenue	12,760,616
31. General Services	1,495,254
32. Health Care	4,665,172
33. General Administration	2,390,540
34. Ownership	1,472,643
35. Special Cost Centers	415,958
35. Provider Participation Fee	122,976
37. Other	0
40. Total Expenses	10,562,543
41. Income Before Income Taxes	2,198,073
42. Income Taxes	0
43. Net Income or Loss for the Year	2,198,073

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